MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
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COMMISSIONERS PRESENT:

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DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA item: Assessing payment adequacy and updating Medicare payments: introduction, measuring changes in input prices in traditional Medicare, physician services
Jack Ashby, Nancy Ray, Tim Greene, Kevin Hayes

MR. HACKBARTH: Now we go into a series of presentations and discussions related to updates for fiscal year 2003. We're going to have a brief introduction, as I understand it, from Jack and Nancy on assessing payment adequacy and then a background piece on input prices from Tim and then we'll go into physician services. Nancy?

* MS. RAY: Thank you. Jack and I are here to briefly review our approach for updating payments in traditional Medicare.

As we see in the diagram, we use a two-part approach for updating payments and traditional Medicare. The first step assesses whether payments are too high or too low. In each service area we tried to look at evidence about the appropriateness of current costs and the relationship of payments with appropriate costs. If evidence does suggest that payments are either too high or too low, then the update recommendation would include an adjustment to the base payment rate.

The second step of our approach is to try to measure how much efficient provider's costs will change in the next payment year. Our approach accounts for expected cost changes primarily through the forecast of input price inflation, an estimate of how much efficient provider's costs are expected to change in the coming year, holding constant the quality and mix of inputs providers use to furnish care and the types of patients they treat.

Then the final update, as depicted in this figure, combines the two percentage changes.

Today you will be making payment recommendations for six fee-for-service service sectors. We will be applying this two-step framework in each of these service sectors. We will be asking you to come to conclusions about payment adequacy for each of these sectors and about expected changes in efficient provider's costs in the coming year.

Jack and I would be happy to address any questions you may have about your mailing materials or my very brief overview. Tim will immediately follow our presentation with a more in-depth analysis of measuring changes and input prices for fee-for-service providers. Following that, Kevin will present the physician payment update. And then, immediately after lunch, you will consider updating hospital payment rates and you will be considering both inpatient and outpatient together.

Then to conclude your day you will be presented with payment update discussions about dialysis, home health, and SNF. That's all I have.

MR. HACKBARTH: Okay. Tim?

* MR. GREENE: Good morning. I will be discussing the section

of chapter two dealing with input price measures used to update payment rates. I will conclude with a draft recommendation on treatment of wages and input price measures. This is both to review the section in the March report and also as background for the further discussions of updates as we proceed.

The section in the draft recommendation are at tab D of your briefing materials.

All the payment systems operated by Medicare use input price indexes to determine price change. CMS and the Congress use these measures to update payment rates and you use the measures and market baskets in your decisionmaking on payment update recommendations.

This returns to some of our discussion from last month. Most input price indexes are calculated by constructing a weighted sum of individual price measures. First, input categories or components are identified to reflect the range of products that a provider purchases to produce patient care. For each input category a price proxy is chosen to measure price changes and is weighted by its relative importance in provider purchases.

For example, the input price index used in the inpatient PPS uses 10 proxies for wages and salaries, 10 for employee benefits, and 20 for all other non-labor related costs other than capital. The other price indexes are comparable or involve somewhat smaller numbers of cases.

Briefly, the input price measures used by CMS in the price indexes generally use producer price indexes from Bureau of Labor Statistics and various wage and benefit measures also from BLS to measure input prices and labor costs respectively.

CMS uses a different input price measure for each Medicare fee-for-service program. The inpatient prospective payment system uses the PPS hospital input price index for operating costs and a capital input price index for capital costs. These are referred to respectively as the PPS hospital operating market basket and capital market basket respectively. The operating market basket is used both for inpatient services and also to update the outpatient prospective payment rates.

The payment system for hospitals paid under TEFRA rules, which are exempt from inpatient PPS, use a market basket referred to as the exempt hospital market basket. The payment system for SNFs uses a SNF market basket similar to the hospital market baskets. Similarly, the home health agency PPS uses a home health specific market basket.

CMS does not currently maintain a market basket to measure prices or update payments for outpatient dialysis services. However, BIPA required that the Secretary develop such an index and we understand it's currently under development and will be reported by this coming July.

Finally, the sustainable growth rate system for updating physician payments under the Medicare fee schedule uses a measure

called the Medicare economic index. I'll be discussing that as we go along but Kevin will be coming back and discussing it in greater detail during his presentation.

As we discussed last month, major policy issue in the design of market baskets is the treatment of wages. Labor costs combining wages and employee benefits account for over half of total expenses in the market baskets we look at. That ranges from about 61 percent for PPS hospitals to almost 78 percent for home health agencies.

As you know, wage levels and trends for health care workers often differ substantially from trends in the overall economy. For example, staff shortages now affect a number of health care occupations, pharmacists, registered nurses and so on. These may lead to wage changes in coming years that may differ substantially from trends in the overall economy.

Proxies for labor costs used in market baskets can be chosen on a number of grounds. First, they may be based on wages and benefits paid to employees in the general economy or to employees in the health sector overall or for individual settings, like acute care hospitals or skilled nursing facilities.

In addition, in designing market basket, one needs to specify what occupations one is looking at, professional employees or all employees or whatever. Here we might be looking at occupational categories that apply to the general economy or that may be specific to the health sector overall or to individual settings, again hospitals or whatever.

In practice, though we may want to have occupational categories specific to health care and types of occupations, we generally have to make tradeoffs between occupational specificity and industry specificity, that is health care or health sector health individual settings. Generally, BLS does not provide wage and benefit indices specific to narrow categories such as hospital nurses or nursing home professionals and so on.

Finally, in the 1980s, policymakers were concerned that inclusion of health industry wage measures in the PPS hospital market basket would allow hospitals to increase wages more rapidly than necessary, thereby increasing the market basket in future Medicare payments. Consequently, CMS made extensive use of wage and benefit proxies from the general economy in constructing its market basket. It did so basically as a cost containment measure to prevent this feedback effect of industry behavior effectively determining future payment rates.

In the 1990s now, pressure from HMOs, other private insurers, and from public prospective payment systems has increased substantially. We think now that the concern with unwarranted wage increases as a way to game the system is misplaced now and is not a source of concern. It's no longer a reason to avoid using health or industry or sector specific wage proxies as was feared 10 years ago.

Increases in health sector wages have not tracked those of

the general economy closely since 1990. Here I compare the employment cost index of BLS wage and salary measure used in many of the market baskets for using their employment cost index for all health care workers on one hand and all workers in the general economy on the other.

As you can see, from fiscal year 19990 through fiscal year 1993, the employment cost index for wages of health care workers increased more rapidly than the index for employees in the overall economy. This reversed and was followed by six years during which health care worker wage increases were significantly less than those in the general economy. The differences were substantial with average annual wage growth for health workers 1 percent faster from 1990 through 1993 and then 0.8 percent lower from 1994 through 1999, when the trends reversed again and health wage growth has exceeded that for the economy as a whole.

The differentials led to a cumulative divergence between health wages and general economy wages that amounted to 5.2 percent over the six year period. Now over the entire 1990 to 2001 period, the divergence in this period is offset by movements the other way in other periods, but six years is a long time to see a differential develop and grow.

As I indicated earlier, health labor costs can and, as we've seen here, have diverged greatly from those in the general economy. The prospect of staff shortages of the sort I mentioned raises the possibility of future wage increases which may continue the pattern we're seeing now of health care wage increases exceeding those in the general economy for a period.

These health sector wage increases would differ from those in the general economy, would not be reflected by use of wage and benefit proxies based on general economy trends. On the other hand, use of health sector specific proxies in the market baskets would automatically reflect the effects of staff shortages if they occur in the market basket forecasts and eventually in the updates made for Medicare payments.

I will now turn to the draft recommendation on the treatment of wages and CMS market baskets. This addresses directly and specifically the use of general economy versus health specific wage and benefit measures in the market baskets. We suggest the Secretary use more appropriate wage and benefit proxies in all input prices indexes used for updating payments, the ones we're discussing now.

In particular, we suggest that in determining index weights, relative importance to attach to various proxies in calculating the market baskets, measures specific to health sector and health sector occupation should be emphasized, should be given greater weight. As you can see, in table 2.1 of your briefing materials, CMS makes substantial use of index specific to individual settings in the health sector as a whole, and in the existing market baskets.

However, this choice does not appear to be a guiding rule.

And in particular, the weight given to general economy indexes is substantial. In the case of hospital market baskets, both PPS and exempt, approximately two-thirds of wage growth is explained by indexes for wages in the general economy compared to one-third for hospital workers. This has the effect, as described earlier, of not reflecting health specific wage growth in the calculation of the market basket.

We can discuss the recommendation now and we'll consider drafting --

MR. HACKBARTH: Tim, I think I understand the overall issue, but I'm not sure I understand the specific language of the recommendation. As I understand the overall issue, all other things being equal we would like the input price measures to accurately reflect the costs of the various provider groups. And we're concerned that that doesn't happen now because they're not using health sector specific wage measures.

The reason for not doing that historically was the concern about this feedback effect, that if we gave them health specific wages that it might be inflationary. Concern about the feedback has diminished because of pressures in the private market and so it's less of an issue than it seemed at one point in time.

So the general direction we're suggesting is let's use health specific measures of wages and benefits, which incidentally would help avoid problems due to shortages, for example, of nurses. If there are shortages of nurses there won't be a direct feedback into our input price measures.

So that's sort of the big picture, as I understand it.

Now the draft recommendation has two sentences in it. The first says the Secretary should use more appropriate proxies, wage and benefit proxies, as opposed to saying the Secretary should use health sector specific proxies. Why not say health sector specific? More appropriate is sort of a vague term.

MR. GREENE: We're trying to be as broad as possible. In some cases, such as the MEI, there may not be very narrowly targeted physician --

MR. HACKBARTH: Specific where available, or something like that?

DR. NEWHOUSE: I had written in the same change, but I would address Tim's issue by adding at the end of the sentence -- so I would say the Secretary should use health specific wage. And then at the end of the sentence I would say for occupation categories where health industries have large shares. Now that leaves large to be defined. For janitors, we'll use some kind of index appropriate for janitors. For nurses, we'll use nurses.

The other thing, I would make a stronger statement in the text about the reason for the feedback mechanism. I think it's flawed. The feedback mechanism assumes hospitals nationally collude on their wages, which doesn't make any sense. I don't think it's managed care that did this in. I don't think it was ever there.

MR. HACKBARTH: I think both arguments were in the text.

MR. GREENE: The first one you're making, which is probably the more important, doesn't get as much attention and emphasis.

MR. HACKBARTH: I agree with the substance of your point. Now the second sentence in the draft recommendation in determining index weights, measures specific to the health sector and its occupation categories should be emphasized. I guess that's fine as it stands.

DR. NEWHOUSE: I think it can go.

MR. HACKBARTH: Just eliminate it all together?

MR. GREENE: That's important because as I indicated, and as you can see, CMS does make extensive use of health industry measures now, and uses civilian hospital employee measures for a large part of the hospital market basket, but it gives them relatively low weight, one-third in the hospital market basket.

So the question of relative importance is crucial. We can't simply say use health industry measures, especially when they don't exist or are not immediately on target. And that doesn't get around the fact of when you use both you want the health industry measures to have the greatest weight. So the weight point is important.

DR. WAKEFIELD: Tim, I think you make a really good case for this recommendation and I support it and even more the refined language that's just been recommended. I've got a related question.

Do you have any idea how difficult this will be for CMS to do, if they chose to do it? And how long that process might take? Part of the reason why I'm asking you this is because I don't know if it's the case or not, but I remember in our June report we made a recommendation dealing with wage index that asked for a faster phase-out of the teaching physician and resident cost from the wage index, for example. And again, I don't know if this is true or not, but I heard that to operationalize that recommendation was going to be quite difficult for CMS to do. I'm not sure if that's the case, I don't know if staff ever heard that or not.

But that concern that I heard prompts this question now, and that is again, have you any idea how long it would take for CMS to actually operationalize this recommendation or how difficult it will be for them to do? Reiterating that I strongly support it.

MR. GREENE: I think it's straightforward. We're not talking about primary data collection, developing new indexes or anything. We're talking about choosing among basically existing Bureau of Labor Statistics measures and incorporating those choices as part of their regular rebasing and market basket revision process, which they will be undertaking now. People from CMS are here and can reply or qualify that if they wish.

But I think it's a series of judgments that will be made in an ongoing process at this time.

MR. HACKBARTH: So this could happen for 2003, fiscal year 2003?

MR. GREENE: I believe so.

MR. HACKBARTH: This is a draft recommendation that I think actually is in response to conversation that we had. So I think there's full support for this, so I don't want to spend any more time than is necessary.

MR. FEEZOR: I was just going to echo, I think, something more akin to what Joe indicated would be something I'd be very supportive of. But just one question, Tim. Nursing turnover in many hospitals normally runs 15 to 20 percent a year, and increasingly it seems that signing bonuses and other economic and some non-economic incentives are provided as a means to attract labor. I'm just curious, how does that get captured in wage indexing? Any idea?

MR. GREENE: I'm not sure. I don't know the BLS data that well. I gather that the, at least until recently available BLS data, it was not reflecting significant increase in nurse wages but I don't know the data firsthand and I can't give you a concrete response.

MR. HACKBARTH: So the draft recommendation would be amended to say, the Secretary should use health sector specific wage and benefit proxies?

DR. NEWHOUSE: I would add at the end, for occupation categories where health industries have large shares. Where you have a small share you're not going to have a health industry specific index anyway.

MR. HACKBARTH: Like a janitor. Given that those are pretty minor changes, I don't think we need to have this brought back tomorrow. Are people prepared to vote on this now?

All opposed to the draft recommendation?

All in favor?

Abstain?

Okay, thank you, Tim. Kevin, physician services.

* DR. HAYES: Good morning. We have two topics to cover this morning. The first has to do with replacing the sustainable growth rate system and the second has to do with an update recommendation for 2003 for physician services.

I've got seven slides here, the last one on the update recommendation, the other six having to do with replacing the SGR system. They're all closely related. I could go over them in just about any order. It would probably be best for me if we just go through them all, including the recommendations, and then come back for discussion.

The first thing I'd point out is that our work on replacing the SGR system is timely. The conference report for the Labor HHS Education Appropriations bill that was passed by the Congress last month included a request for a MedPAC study on this issue. The conference report language began with an expression of concern about the 5.4 percent reduction in payment rates that

went into effect January 1st and went on to ask that MedPAC study replacing the sustainable growth rate with a factor that more fully accounts for changes in the unit cost of providing physician services. Findings and recommendations are due March 1st, which is the due date for our March report, so addressing this issue in the March report will fulfill this requirement.

Which brings us then to our first draft recommendation, having to do with how the Congress could replace the sustainable growth rate system. This recommendation really has two components. The first has to do with repealing the sustainable growth rate system and instead requiring the Secretary update payments for physician services based on the estimated change in input prices for the coming year.

This, of course, is the update method that we've been talking about throughout the fall for other services, the one that Nancy summarized just a few minutes ago. And so there's not much more to say about that.

But there are a few things to say about the second component of this recommendation, having to do with the adjustment for productivity growth. There is another recommendation to follow in a few minutes on the details of multifactor versus labor only productivity. But for now let me just say that the recommendation is proposing here that there be a reduction in the update for productivity growth.

We are proposing no such reduction for other services on the assumption that cost decreases related to productivity growth will be offset by cost increases due to scientific and technological advances and other factors.

In the case of physician services, it's not clear that those other cost increasing factors, S&TA and such, are great enough or large enough to offset productivity growth when it comes to physician services. So this recommendation has that clause in it.

The other point that I would make about this recommendation is that it implies that the Congress has the option of deviating from updating payments based on changes in input prices for any given year. The Congress, of course, has done so many times for inpatient hospital care, for example, and could do so if this recommendation were adopted.

The next slide talks about the rationale for the recommendation. It's really aimed at making the update method for physician services similar to that for other services. This would take us a step toward making payment policy for physician services more consistent with that for other settings.

The other thing that would be accomplished here is that it would solve problems with the sustainable growth rate system. It would allow the updates to better account for factors affecting costs and it would decouple payment updates from spending control. In effect, what the Commission is saying with a recommendation like this is that the update mechanism is not an

appropriate tool for achieving spending control.

To make this all happen, we have a slide here which has to do with next steps. Several steps would be necessary here. The first one, of course, would be changing current law to repeal the SGR system. Also, there is the matter of changing the measure of input prices that's available, the Medicare Economic Index, changing it to a forecast. This is something that the Commission recommended in its March 2001 report. It seems to make sense in that the whole idea behind updating payments is to anticipate changes in cost for the coming year. The MEI currently looks backward at payment changes for the previous year.

Other useful steps have to do with the productivity growth adjustment that's in the MEI currently. The Commission talked at the December meeting about the advisability of separating out that productivity adjustment and considering it separately in update decisions.

The other thing to say about productivity growth has to do with that current adjustment. It currently applies or addresses just changes in the productivity of the labor inputs and we could see a rationale for changing that adjustment to make it apply to all inputs.

That brings us then to our next recommendation, which is that the Secretary should revise the productivity adjustment for physician services and make it a multifactor instead of labor only adjustment.

The first thing I would say is that multifactor productivity is a measure of changes in productivity for all inputs, labor and capital. And a rationale for adopting this recommendation would be first that both types of inputs are used in the delivery of physician services. Labor inputs are very important, of course, but other inputs, capital related inputs having to do with office space, supplies, equipment and so on, are also relevant.

The other point to make about this recommendation is that changing the productivity adjustment would make it consistent with modern methods for analyzing productivity growth. The current labor only adjustment in the MEI has been in place more or less in its current form since 1975 when the MEI was created. Since the Bureau of Labor Statistics has done a lot of work to improve methods and data available on multifactor productivity.

For calculations in the draft chapter, we assumed an adjustment for multifactor productivity of 0.5 percent. That's a standard that the Commission has used for other services. Current data from the Bureau of Labor Statistics suggests that perhaps that adjustment is a little low.

Next, we should talk for a minute or two about the budgetary impacts of replacing the sustainable growth rate system. They are important and I'd like to deal with the two impacts individually.

The first has to do with removing spending control. As you know, the sustainable growth rate system is a tool for achieving

spending control. It does so by establishing a target, if you will, for growth in the quantity and intensity of services that Medicare beneficiaries receive, physician services. That target is growth in real GDP per capital. If the SGR system is replaced, that target will no longer be relevant.

Any difference between real GDP per capita and growth in beneficiary use of services will no longer be fed back through to payment rates via the update mechanism. And so, taking that feedback loop away will result in an increase in projected spending for physician services. As you can see here, it's 0.6 percent.

The other spending impact has to do with changing the productivity adjustment. The current adjustment out through 2006 is 1.6 percent. If we were to replace that with the productivity standard that the Commission uses of 0.5 percent, we've got a difference of 1.1.

Now that assumes that that phrase in the first recommendation having to do with lessen adjustment for productivity growth stands. But if that goes away, then this estimate would go up by 0.5 percentage points.

So we have a total spending impact estimated of 1.7 percent per year.

So if we apply this new update approach to information we have for 2003, we come up with an update recommendation of 2.5 percent. This is the estimated change in input prices for physician services, a forecast for 2003 of 3.0 percent. And then less that productivity adjustment of 0.5 gets us to the 2.5 percent that you see here.

That's all I have.

DR. ROWE: When would this occur?

DR. HAYES: January 1, 2003. The update cycle for physician services is calendar year.

DR. REISCHAUER: I was wondering why we recommend to the Secretary, or to the Congress, a procedure or a method here for updating that isn't as sophisticated as the one we've adopted for ourselves? I mean, we've adopted for ourselves a system where we first look at the base and say is it adequate. And yet, there's nothing in here saying that the Secretary should consider that.

And while S&TA may not be important right now, it might be important five or 10 years from now. Maybe we should include productivity net of any cost increasing factors like that. I mean, why shouldn't we be recommending, in a sense, a full hand to Congress and the Secretary, when we're using the full hand to make a recommendation?

DR. HAYES: My reply to that would be, on the issue of payment adequacy, whether the current base is right, recall the point that the Congress can step in and change the update in any given year based on recommendations from us, on CMS, having to do with these matters. When we look at language in the Social Security Act on the update for say inpatient hospital care, it's

just like this. It's the market basket increase. Sometimes it's adjusted up or down in a given year. But otherwise, it just says market basket increase.

And so the discretionary part of the process of considering access and entry and exit and all that kind of thing would be something that the Commission would include in its update recommendation to the Congress and then it would be up to the Congress to deviate from what's described in the recommendation.

DR. REISCHAUER: But we were there a year ago and we decided to change. It strikes me that it's useful not only to have the MedPAC staff look at the adequacy of the base, but if the Secretary and CMS staff were also trying to answer that question, we might get a better answer to it on which Congress could then base its decision.

MS. BURKE: Bob, are you suggesting a change in the statute that references that? I mean, in recommending a repeal of SGR, are you suggesting that we replace that in a statutory way with language that requires a certain presumption in setting rates? Or are you just saying in directing the Secretary? I'm just trying to understand your intentions.

DR. REISCHAUER: We are suggesting that SGR be repealed. Now something is going to have to replace it, and presumably you would have language saying these are the considerations that the Secretary should take into account, just we've taken them into account.

MS. BURKE: As a general matter you don't do that in statute.

DR. REISCHAUER: In the report that you would --

DR. NEWHOUSE: We did do it in PPS.

MS. BURKE: We did do it in PPS. And we have done it historically in nursing homes and other places. We've gone through this game in a variety of ways.

DR. REISCHAUER: I'm just thinking about the confusion that would result if the Secretary is supposed to come up with something that is a prospective judgment on price increases minus multifactor productivity and it comes out to 3 percent and MedPAC comes along and says it really should be 6 percent because our judgment is that the base is horrendously inadequate. And then everybody makes a big deal out of a difference that may not exist.

In fact, the Secretary might think no, that they're dead on, the base is too low.

MS. BURKE: I'm always leery of statutory language if you can avoid it, if we can achieve our end some other way. Once it's there it's tough to...

DR. ROSS: I was just going to ask Bob, sort of by extension when we get to the hospital discussion and the other facility discussion, are you going to add that in, too? I guess I'd parallel Sheila --

DR. REISCHAUER: You can defeat me now and I'll shut up.

DR. ROSS: That's up to the other commissioners, not to me, but I guess the question is do you want to give the Secretary total discretion here? Because that's essentially what you'd be saying if you put this in statutory language.

DR. REISCHAUER: The question is whether you're asking the Secretary to provide a judgment about prices or a judgment about what he thinks the increase should be.

MR. HACKBARTH: Maybe the middle ground here is that for purposes of protecting the relative prerogatives of the Congress and the Executive branch, the Secretary ought to be asked to do this: say what the increase in input prices with the multifactor adjustment would be, invite the Secretary in language to suggest other considerations for the Congress to take into account just as MedPAC does. But not write a statute that basically gives the Secretary carte blanche to determine the proper update. So invite comments to supplement this number, this calculation. Don't grant the Secretary, in statute, absolute freedom.

MS. BURKE: Can I just ask a factual question? If in fact we are successful in our suggestion that we repeal SGR, what remains in the statute, specific with respect to physician reimbursement?

DR. HAYES: There's everything about the fee schedule, of course, which is geographic adjustments and relative value units and the whole thing, requirements for updating the relative value units from one year to the next to make sure that the relatives among services are right. And that's it.

MS. BURKE: Let me just suggest that before we go down this road, if we're going to come back to this, let's actually factually find out what's in the statute before we start playing around with making statutory recommendations, other than the repeal which is explicit. But let's do a reality check in terms of what is already in the statute and whether what we want to do going forward is statutory or by nature of language recommendations.

I mean, I don't know whether the statute needs changing at all, other than the repeal.

DR. NEWHOUSE: I think Bob is right, it has to be replaced with something because it, itself, replaced the VPS which then came out of the statute. Now this is there, it's going to come out of the statute so there's just a void on the update mechanism, basically.

MS. BURKE: So what's left?

DR. REISCHAUER: Is the Secretary's recommendation or whatever he comes up with the default unless Congress acts?

MS. BURKE: That's what I -- I mean, I want to look at 18 and see.

DR. REISCHAUER: If that's the case, as opposed to just the Secretary making a recommendation about what he thinks the increase in price is going to be. You know, we've said less an adjustment for growth and multifactor productivity. The number

we've put in, 0.5, I'm not sure that's a consensus among economists of multifactor productivity. I thought it was closer to 0.7 for the economy as a whole.

MS. BURKE: Whether you put the number in the statute or just the process?

DR. REISCHAUER: No, you put in the process but we're going to come up with a different recommendation, even if we see the world the same way if our view of multifactor productivity is different from BLS' or BEA's.

MS. BURKE: Let's just step back and take a breath and see what's actually there.

MR. HACKBARTH: So there are two questions about what's there. One would be, if we repeal SGR what remains with regard to physician services? Then the other is exactly how are all the others structured? And what we want is some parallelism between where we end up with physicians and what we have for the other providers, inpatient hospital, et cetera.

DR. ROSS: That's what the recommendation on the table would give is consistency with, I believe, almost all of the other payment systems in Title 18.

DR. NEWHOUSE: Productivity adjustment, which we think is a legitimate distinction.

DR. ROSS: No, with MedPAC framework it's consistent with that.

DR. NEWHOUSE: It's consistent, yes.

DR. ROSS: The reason you don't see it explicitly, say for hospital services -- well, I won't say the reason it's not in Title 18, but MedPAC's going in position as you've discussed is that the default until you see otherwise is market basket and the Commission has tentatively reached the judgment that increasing costs associated with scientific and technological advance are approximately offset by a policy judgment that they'll be financed with a productivity adjustment.

Here the assertion that staff have brought you is that most of the increases that we can think of through S&TA are likely to come through new codes being introduced. So it's automatically taken care of in that mechanism and we're adopting the same standard for, if you will, financing those, so to speak, with an explicit adjustment for productivity.

And that's why you'd write language slightly differently for the docs than you would for the hospitals.

MR. HACKBARTH: What I like about this approach is that people can read the boldface recommendation and get a clear sense of the direction that MedPAC is suggesting we go with physician services. We're not writing statutory language, really, here.

I think then in the text beneath the boldface recommendation we can say the MedPAC framework involves an assessment of payment adequacy in various factors. And we would love and we're sure the Congress would love to hear whatever analysis the Department can bring to bear on those issues, as well.

DR. REISCHAUER: I will accept that as an adequate response.

MR. HACKBARTH: The second draft recommendation, the Secretary should revise the productivity adjustment and make it a multifactor instead of a labor-only adjustment. I just need a clarification, Kevin. The 0.5 percent, or Bob's now suggesting 0.7 percent might be the number, those were 10-year averages or something like that, right?

What I'm trying to get at is are we asking that each year the Secretary look at the most recent BLS number on multifactor productivity and have it balance up and down? I understand these numbers do move a lot due to cyclical changes in the economy. Or are we suggesting a number that's smoothed and it reflects long term trends?

DR. HAYES: What I can tell you, I think that this recommendation gives the Secretary some discretion over how to proceed. That discretion is consistent with current policy. The labor-only adjustment in the MEI is a 10-year moving average. And so the assumption would be that the Secretary would go through a process, as was done in the past, to determine the labor-only adjustment and decide what kind of factor would be appropriate but in measuring multifactor productivity.

MR. HACKBARTH: What has MedPAC done in the past? For example, on the hospital side, we have looked at long-term averages as opposed to adjusting our policy factor up and down based on cyclical changes in the economy.

DR. HAYES: I might invite my colleague Jack Ashby to the table to explain that, but my understanding is that it was a matter of looking at the experience with multifactor productivity in the early to mid-90s and setting a target.

MR. ASHBY: Right, that 0.5 figure was indeed a 10-year average, also. But it developed a couple of years back. And as both Kevin and Bob have alluded to, we've had a couple of years of high productivity growth in the meantime, so the average has probably risen a bit.

But let me also comment that when we developed this in the hospital context, we didn't necessarily think of it as being as precise as a rolling 10-year average that we would adjust every year. As long as it was generally capturing the long run phenomenon, we were going to leave it at that 0.5. But in this context, you might take a different answer and suggest that it formally be a 10-year rolling average.

MR. HACKBARTH: The point I want to make is not to tie us into a particular formula, but I hate to see this balancing up and down. I think some stability --

DR. REISCHAUER: I don't think it bounces as much as your bad dreams might think it does. And I think maybe in the text if we say something about a trend productivity, without making it clear whether it's the past trend or the future trend, it will give the --

MR. HACKBARTH: That would get to my point, yes.

DR. REISCHAUER: And whether it's five years or 10 years or whatever.

DR. HAYES: Just from a historical perspective, the very reason why CMS adopted a 10-year moving average on labor-only productivity was because of the bouncing around problem and a need to smooth it out a bit. And so I'm not recalling exactly when that change was made, but that is certainly the rationale for it.

MR. HACKBARTH: Good. I like Bob's idea. The point here is trend as opposed to annual.

Also, in this same draft recommendation, multifactor is technical language that many people in our audience won't understand. Could we use something like account for the productivity of all inputs, as opposed to just labor? David can even improve on what I offered. But multifactor sounds a little bit too much like technical jargon for our reports. It can be in text, but not in the recommendation.

DR. NEWHOUSE: But there is formally a number that corresponds to multifactor and is labeled multifactor productivity.

MR. HACKBARTH: Again, maybe I'm making too much of this but I think a big percentage of our audience reads only the recommendations and I'd like them to be able to understand the recommendations when they read them. We can include multifactor productivity in the text explaining it, for those who delve more deeply.

DR. REISCHAUER: I would suggest you go the other way around. Leave multifactor here and explain it in the text. It is a technical term and there is a line in the BEA numbers that has multifactor --

DR. NEWHOUSE: It's like trying to say we should use the output of all goods and services rather than GDP.

MR. HACKBARTH: I give up. Do I have to roll on my back?

DR. ROWE: So let me make sure I got the record straight. The chairman suggests that we make the recommendations so people understand them when they read them, and other people disagree with that recommendation.

[Laughter.]

DR. REISCHAUER: Why do doctors do everything in Latin?

MR. HACKBARTH: Any other comments? Are we ready to vote?

DR. NELSON: Are you receiving comments on the narrative at this point?

MR. HACKBARTH: Sure. I welcome comments on the narrative.

DR. NELSON: I'm making these comments on the narrative with the understanding that there are going to be audiences reading this report for whom some of these points are important, apart from the Congress.

On page six, Kevin, in talking about beneficiary access to care, the point is made that evidence of widespread problems with access means that the payments are too low. But in the absence

of that the payments are probably about right or may be too high.

I'd like to see that sentence deleted because quality could still be up, even though payments were too low. And it implies that physicians would take care of a diabetic or a patient with a heart attack differently depending on the payment source, which I think is generally not the case. This is mainly in the context of a quality reference, not the access reference.

With respect to the willingness to serve referenced on page seven, again just pointing out that the willingness of physicians to serve Medicare patients is based on '99 data when the updates were high. I'd like to see a sentence that qualifies that and expresses some concern that with a reduction in the conversion factor, perhaps in 2002, that the impact of that is not been measured at this point.

On page nine, in accounting for the cost changes in the coming year, the impact of the regulatory burden may be substantially higher with the impact of the HIPAA requirements. I think it's worth a sentence to point out, since looking forward, indeed the costs associated with that may be substantially larger.

I think our assessment of the PLI premiums may be understated since in many parts of the country those premiums are exploding. A sentence to reference the unknown impact of that, it seems to me, wouldn't hurt the report. It's true that these practice expenses are accounted for in the RUC process, but there's a five year lag in that process. So our estimates of that in the costs should include those.

Finally, on page 14, you talk about increasing productivity and the potential for new technology to be applied in that context with some examples of new technologies that are expected, perhaps, to improve productivity. I think it also wouldn't hurt to have a sentence pointing out that new technologies may also decrease productivity, depending on how productivity is defined.

But if you're talking about the number of patients that a doctor can see or the efficiency in their work product, things like e-mail, which increase the work but aren't compensated, aren't paid, so they aren't reflected on the inputs and may very well diminish productivity.

MR. FEEZOR: I just wanted to underscore Alan's comments on the PLI, and particularly that's a cyclical issue. But when the spikes occur, as they do after major events and disruptions in the market such as we've had this year, we had in the late '80s, they do jump up. And I question whether we capture that fast enough.

And then if you look, particularly on the provider institution side, with the major withdrawal of one of the major professional liability carriers from the marketplace right now it's likely to really spike it up going forward. So I think he makes a good point and our report ought to at least try to capture some of that dynamic.

MR. HACKBARTH: Any other comments? Are we ready to vote?

I think where we ended up in terms of the wording of the draft recommendations basically reflect the issues that were raised in the accompanying text, as opposed to modifying the recommendations themselves. So we will vote on the drafts as written, as presented.

Draft recommendation number one, all opposed?

All in favor?

Abstain?

Draft recommendation two, all opposed?

In favor?

Abstain?

And number three, opposed?

In favor?

Abstain?

DR. ROWE: Can I ask a clarification?

MR. HACKBARTH: After the vote?

DR. ROWE: Yes, after the vote. Bob made the point that we had a 0.5 and the equations called for a 0.7. We're not even doing it the way we're suggesting it be done. Is our recommendation bakes in this 0.5, as opposed to what's in the literature, if you will? Where did we wind up on that? We haven't reconciled this; is that right?

DR. REISCHAUER: Implicitly, by recommending a 2.5 percent update we've accepted 0.5. We've been unclear, we're using a dated 10-year moving average of multifactor productivity. The CBO has an estimate, a prospective one. BEA has a more updated one for the past.

It's not going to move around by more than 0.1 or so, 0.1 or 0.2. So it's not something to lose a great deal of sleep over, I don't think.

DR. ROWE: So this is consistent with where we want to go?

DR. REISCHAUER: Yes.

DR. ROSS: And, Jack, it's consistent with where you've been on the facility side. In the next cycle we're free to revisit if you want to refine things. But you're after the decimal place.

DR. ROWE: Thank you.

MR. HACKBARTH: Good job, Kevin. Thank you. We are to the public comment period.